STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING _____ B. WING _____	C 07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, observation and interview,	F 157	F 157 1. What corrective action(s) will be accomplished for those residents found to have been affected: On 7/2/12 the Director of Nursing completed one-on-one education with nurse #1 regarding timely notification to patients' family and physician of skin tears. 2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. From 7/5/12 to 7/18/12, the Director of Nursing RN, Staff Development Coordinator RN and Nursing Scheduler LPN in-serviced nurses on timely notification to patients' family and physician of skin tears. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? The Director of Nursing RN or designee will audit nurses documentation of skin tear incidents for timely notification to patient's family and physician for three months to ensure compliance.	7/18/2012 7/18/2012 7/18/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 7-23-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUL 24 2012

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F 157	Continued From page 1 the facility failed to notify the physician and the family of a skin tear for one (#4) of five residents reviewed. The findings included: Resident #4 was admitted to the facility on November 29, 2010 with diagnoses including Osteoarthritis, Dementia, Hypertension, Atrial Fibrillation, Anemia, History of Fall, Diabetes, Congestive Heart Failure and Muscle Weakness. Medical record review of the Minimum Data Set (MDS) dated June 28, 2012 revealed the resident had short and long-term memory problems with severely impaired decision-making skills; was easily distracted; had disorganized thinking; had physical behavioral symptoms directed toward others; had Hallucinations and Delusions and was totally dependent on staff for all activities of daily living (ADL) . Medical record review of a nurse's note dated June 29, 2012 at 12:00 p.m. by Licensed Practical Nurse (LPN) #1 revealed "Resident bumped old purple discolored area to (left) arm on w/c (wheelchair) causing area to open and make skin tear. Cleansed (with) NS (normal saline) and Steri-strips applied. ADON (Assistant Director of Nursing) aware. Geri sleeve applied." Continued review revealed no documentation the physician or the family was notified of the skin tear. Medical record review of a nurse's note dated June 29, 2012 at 9:30 p.m. ("for 4:40 pm") by LPN #2 revealed "Charting for S/T (skin tear) to (left) elbow. Daughter (#2) brought resident to	F 157	4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place. The Director of Nursing RN or designee will review the notification audit and will report findings monthly times three months to the members of the Performance Improvement Committee including the Medical Director, Executive Director, Pharmacist, Director of Business Development, Business Office Manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. They will review the findings, make recommendations, and make plans of action if any areas are found to be noncompliant.	7/18/2012

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F 157	Continued From page 2 this nurse. Resident noted to have red drainage on geri sleeve. Upon removing geri-sleeve this nurse noted red drainage to it through bandage on arm. Several Steri strips noted. Old Steri strips removed, cleaned skin tear (with) wound cleanser, clean Steri strips applied, covered (with) non adherent pad et (and) covered (with) Kerlex. (Physician) notified...N/O (new order) for padded cushions to wheel chair arms...cleaned et dressed x (times) 2 this shift. An elbow cover was applied..." Medical record review of a nurse's note by the Director of Nursing (DON) dated June 29, 2012 at 4:45 p.m. revealed "Spoke with resident's daughter (#1) regarding skin tear on left arm. Daughter (#2) present. Area cleaned (with) wound cleanser and new Steri strips applied. (Physician) notified." Review of the facility's investigation dated June 29, 2012 revealed "...several Steri strips applied to skin tear that measured approx. (approximately) 2 inches." Observation on July 10, 2012 at 12:40 p.m. in the dining room revealed the resident was being fed the lunch meal by a restorative Certified Nursing Assistant (#1). Continued observation revealed both arms of the wheelchair were covered with thick padding and an elbow cover was in place under the long-sleeved clothing. Interview on July 10, 2012 at 1:30 p.m. in the conference room with LPN #1 (on duty June 29, 2012 on day shift 6:00 a.m.-2:00 p.m.) confirmed the resident was observed with a skin tear on June 29, 2012 at 12:00 noon. Continued	F 157		

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F 157	Continued From page 3 interview confirmed LPN #1 did not notify the physician or the family of the skin tear before the LPN's shift ended at 2:00 p.m. Telephone interview on July 11, 2012 at 9:30 a.m. with the DON confirmed the DON notified the physician of the skin tear at 4:45 p.m. on June 29, 2012. Continued interview confirmed the DON had no knowledge the physician had been notified prior to 4:45 p.m. Telephone interview on July 11, 2012 at 11:00 a.m. with LPN #2 (on duty June 29, 2012 on 2:00-10:00 p.m. shift) confirmed LPN #2 observed active bleeding from the geri sleeve which was in place on the resident's left arm. Continued interview confirmed LPN #2 was made aware of the bleeding by the family of resident #4. Continued interview revealed LPN #2 removed the geri sleeve; observed bleeding through a Kerlex bandage; removed the Kerlex and observed "six to eight" Steri-strips in place on the skin tear. Continued interview revealed the day shift LPN (#1)informed LPN #2 the resident had a skin tear but did not report the size or condition of the skin tear. Continued interview with LPN #2 confirmed the physician was not notified of the skin tear until 4:45 p.m. (by the DON). C/O #30077.	F 157		

JUL 24 2012